Summary of Benefits for 10-1-2015 through 9-30-16

Lake County Board of County Commissioners 64550

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice PPO	BlueCare HMO
Deductible (DED) (Per Person/Family Agg)		
In-Network	$750 / $2,250	Not Applicable
Out-of-Network	Combined w/In-Ntwk	
Coinsurance (Member Responsibility)		
In-Network	20%	Not Applicable
Out-of-Network	40%	
Out of Pocket Maximum (Per Person/Family Agg)		
In-Network	$3,000 / $6,000	$3,000 / $6,000
Out-of-Network	Combined w/In-Ntwk	Not Applicable
Lifetime Maximum	No Maximum	No Maximum
PROFESSIONAL PROVIDER SERVICES		
Allergy Injections (for testing, see place of service)		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	DED + 40%	Not Covered
E-Office Visit Services		
In-Network Family Physician	$20	$20
In-Network Specialist	$35	$35
Out-of-Network	DED + 40%	Not Covered
Office Services		
In-Network Family Physician	$20	$20
In-Network Specialist	$45	$45
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician	DED + 20%	$0
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Provider Services at Other Locations		
In-Network Family Physician	DED + 20%	$0
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Radiology, Pathology and Anesthesiology Provider Services at Hospital or Ambulatory Surgical Center		
In-Network Specialist	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
PREVENTIVE CARE		
Adult Wellness Office Services		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	40% (No DED)	Not Covered
Colonoscopies (Routine) With diagnosis, subject to applicable deductible, coinsurance or copays based on location of service.		
In-Network	$0	$0
Out-of-Network	40% (No DED)	Not Covered
Mammograms		
In-Network	$0	$0
Out-of-Network	$0	Not Covered
Well Child Office Visits (No BPM)**		
In-Network Family Physician	$0	$0
In-Network Specialist	$0	$0
Out-of-Network	40% (No DED)	Not Covered

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice PPO	BlueCare HMO
EMERGENCY/URGENT/CONVENIENT CARE		
Ambulance		
In-Network	DED + 20%	$0
Out-of-Network	In-Ntwk DED + 20%	$0 May be balance billed
Convenient Care Centers (CCC)		
In-Network	$20	$20
Out-of-Network	DED + 40%	Not Covered
Emergency Room Facility Services (also see Professional Provider Services)		
In-Network	$250	$250
Out-of-Network	$250	$250
Urgent Care Centers (UCC)		
In-Network	$50	$50
Out-of-Network	DED + 40%	Not Covered
FACILITY SERVICES - HOSP/SURG/ICL/IDTF Unless otherwise noted, physician services are in addition to facility services. See Professional Provider Services.		
Ambulatory Surgical Center		
In-Network	DED + 20%	$200
Out-of-Network	DED + 40%	Not Covered
Independent Clinical Lab		
In-Network (Quest Labs)	20% (No DED)	$20
Out-of-Network	40% (No DED)	Not Covered
Independent Diagnostic Testing Facility - Xrays and AIS (Includes Physician Services)		
In-Network - Advanced Imaging Services (AIS) (MRI, MRA, PET, CT, Nuclear Medicine)	$75	$75
In-Network - Other Diagnostic Services (e.g. X-ray)	$50	$50
Out-of-Network	DED + 40%	Not Covered
Inpatient Hospital (per admit)		
In-Network	DED + 20%	$300 per Day up to $1,200
Out-of-Network	$300 Copay + DED + 40%	Not Covered
Outpatient Hospital (per visit)		
In-Network	DED + 20%	$300
Out-of-Network	DED + 40%	Not Covered
Therapy at Outpatient Hospital		
In-Network	DED + 20%	$20
Out-of-Network	DED + 40%	Not Covered
MENTAL HEALTH AND SUBSTANCE ABUSE		
Inpatient Hospitalization		
In-Network	DED + 20%	$150 per Day up to $750
Out-of-Network	DED + 40%	Not Covered
Outpatient Hospitalization (per visit)		
In-Network	DED + 20%	$200
Out-of-Network	DED + 40%	Not Covered
Provider Services at Hospital and ER		
In-Network Family Physician or Specialist	$0	$0
Out-of-Network Provider	$0	Not Covered
Physician Office Visit		
In-Network Family Physician or Specialist	$20 / $35	$20 / $35
Out-of-Network Provider	40%	Not Covered
Emergency Room Facility Services (per visit)		
In-Network	$50	$100
Out-of-Network	$50	$100
Provider Services at Locations other than Hospital and ER		
In-Network Family Physician	$45	$0
In-Network Specialist	$45	$0
Out-of-Network Provider	DED + 40%	Not Covered
OTHER SPECIAL SERVICES AND LOCATIONS		
Advanced Imaging Services in Physician's Office		
In-Network Family Physician	$75	$75
In-Network Specialist	$75	$75
Out-of-Network	DED + 40%	Not Covered
Birthing Center		
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered

COST SHARING Maximums shown are Per Benefit Period (BPM) unless noted	BlueChoice PPO	BlueCare HMO
Medical Equipment and Supplies via CareCentrix		
Diabetic Equipment and Supplies*		
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
All Other Durable Medical Equipment and Supplies		
In-Network	DED + 20%	$50
Out-of-Network	DED + 40%	Not Covered
Home Health Care BPM	30 Visits	40 Visits
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Hospice LTM	No Maximum	No Maximum
In-Network	DED + 20%	$0
Out-of-Network	DED + 40%	Not Covered
Outpatient Therapy BPM (Combined Outpatient Cardiac, Occupational, Physical, Speech, and Massage Therapies)	60 Visits	30 Visits
In-Network	DED + 20%	$20
Out-of-Network	DED + 40%	Not Covered
Spinal Manipulations BPM	26 Spinal Manipulations	26 Spinal Manipulations
In-Network	DED + 20%	$35
Out-of-Network	DED + 40%	Not Covered
Skilled Nursing Facility BPM	90 days	45 days
In-Network	DED + 20%	$100 per day / $500 max
Out-of-Network	DED + 40%	Not Covered
PRESCRIPTION DRUGS		
In-Network		
Retail (30 days)		
Generic/Preferred Brand/Non-Preferred/Specialty	$15 / $40 / $55 / $100	$15 / $40 / $55 / $100
Mail Order (90 days)		
Generic/Preferred Brand/Non-Preferred/Specialty	$30 / $80 / $110 / NA	$30 / $80 / $110 / NA

* Diabetic Supplies (lancets, strips, insulin etc.) are covered under the Rx benefit. Diabetic Equipment (insulin pumps, tubing, etc.) are always covered under the Durable Medical Equipment benefit.

** BPM means **B**enefit **P**eriod (calendar year) **M**aximum and runs from Jan 1 – Dec 31

This is not an insurance contract or Benefit Booklet. The above Benefit Summary is only a partial description of the many benefits and services covered by Blue Cross and Blue Shield of Florida, Inc., an independent licensee of the Blue Cross and Blue Shield Association. For a complete description of benefits and exclusions, please see Blue Cross and Blue Shield of Florida's Benefit Booklet and Schedule of Benefits; their terms prevail.